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ABSTRACT

This paper discusses the integration of educational and mental health services for children and adolescents within a psychiatric day treatment setting at the Bradley School housed in a private psychiatric hospital affiliated with Brown University in Rhode Island. A full range of mental health services are used, and therapies are delivered in the classroom setting by treatment teams composed of psychologists, social workers, and clinicians in training. Psychiatric and medical consultation and treatment are provided on site. Other services include speech/language, occupational, and physical therapies. This program has evolved over two years from one in which the classroom was the adjunct to the treatment program to one in which the classroom is the primary agent of treatment. A 6-week inservice program focusing on the principles of operant conditioning and positive reinforcement was implemented. A study was designed to evaluate the use of behavior management strategies in the classroom, and positive results were found in the decrease in restraints and crisis incidents. As the revised treatment module began to work, community special education programs began to send students for short term diagnostic placements, and a plan is in development for "transition classrooms" intended for children who no longer need intensive treatment but are not yet ready to return to the community. (KM)

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Integrated Educational and Mental Health Services Within a Day Treatment Setting

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Integrated educational and mental health services within a day treatment setting

Greta Francis, Ph.D. and Dale F. Radka, M.D.

The purpose of this presentation is to discuss issues related to integrating educational and mental health services for children and adolescents within a psychiatric day treatment setting. Our program, the Bradley School, is a certified special education placement housed in a private, university-affiliated, psychiatric hospital. We reside at the Emma Pendelton Bradley Hospital, which is affiliated with the Brown University School of Medicine.

The Bradley School provides comprehensive, integrated, and multidisciplinary assessment and treatment for youngsters between the ages of five and eighteen years. We have 10 self-contained classrooms serving approximately 60 children and adolescents. Each classroom of 6 to 8 children is staffed with a certified special education teacher and a child care worker. Each child receives a full range of mental health services including family, individual, and group therapies. These therapies are delivered by psychologists, social workers, and clinicians in training (e.g., child psychiatry fellows, clinical psychology interns and postdoctoral fellows, social work students.) Psychiatric and medical consultation and treatment are provided on site. Adjunctive services include speech/language, occupational, and physical therapies.

A typical day in the Bradley School resembles that of a community school in many respects. Students arrive on school buses in the morning between 8:00 and 9:00. They participate in an exercise program and then have a breakfast snack. The morning hours are spent on academics. The academic curriculum is provided using a combination of individual and small group instruction. At times, classrooms combine for large group projects. The curriculum is taught using experiential methods. For example, the class may take a walk to the Narragansett Bay in order to collect specimens of rocks, shells, and plants. This experience then becomes the basis for their lessons. For example, they will write a story about their trip as an English assignment, calculate the percentages of rocks and shells in their sample as a math assignment, and identify and label the plants as a science assignment. After completion of morning academics, all youngsters in the program have lunch together in the cafeteria. Lunch is followed by an afternoon session of academics. Interspersed throughout the day are physical education, library time, cooking class, music, and art. Individual and group therapies are provided during the school day, while family therapy often occurs after school hours. Each day ends with a "cash-in" during which students have access to a variety of reinforcers contingent upon their behavior that day.

Clinical care of children in the Bradley School is coordinated using a multidisciplinary treatment team model. Our psychiatrist and psychologists serve as treatment team leaders. Teams are

organized around classrooms and include all the professionals working with the children in the classroom. Teams meet weekly in order to coordinate diagnostic assessments, develop and revise treatment plans, and review treatment progress.

The description you've just heard is of our program today. Over the past two years, the Bradley School has evolved from a program in which the classroom milieu was viewed as adjunctive to long-term psychodynamic psychotherapy to one in which the classroom milieu is viewed as a primary agent of treatment. When we arrived in the "old" program, the classroom was seen as a place where patients waited in between individual psychodynamic psychotherapy sessions. Children stayed in the program for years, much to the dismay of special education directors who were charged with finding the "least restrictive" placement for their students. As a result, the census in the program was steadily shrinking.

While we appreciated the importance of individual therapy, we were struck by the lack of attention paid to the classroom milieu as a therapeutic agent. For this reason, we decided to implement behavior management strategies in our classrooms. This seemingly straightforward task was, in fact, quite complicated. Our staff had a number of negative preconceptions about behavior therapy. These beliefs included that the use of behavior therapy excluded building therapeutic relationships, ignored the social context, restricted the child's ability to make choices, and was excessively punitive. In fact, our staff generated a list of 14 negative preconceptions!

After discussing preconceptions, we implemented a six week inservice program for our teachers and child care workers. The inservice included an extensive review of the principles and procedures of operant conditioning. Time was spent developing classroom-wide behavior management programs that were based on priniciples of positive reinforcement. In addition, contingency contracting strategies for individualized programs were reviewed.

We believed that it was important to evaluate whether the use of behavior management strategies in the classroom would improve the quality of clinical care for our students. In order to accomplish this, we examined the frequencies of physical restraints and crisis incidents. Crisis incidents were defined as a child being required to leave the classroom because of unacceptable behavior, e.g., persistent noncompliance.

Our study was a basic pre-post design. Data were collected for 4 consecutive quarters: before the inservice (January to March 1992), during the inservice (April to June 1992), and twice after the inservice (July to September 1992 and October to December 1992). As can be seen in the first graph, the frequency of physical restraints decreased from 67 during the quarter <u>before</u> the inservice to 11 during the last quarter. Similarly, as can be seen in the second graph, the frequency of crisis incidents decreased from 224 during the quarter <u>before</u> the inservice to 66 during the last quarter.

We were encouraged to find the decrease in restraints and crisis incidents. In essence, teachers and child care workers

began to deal with children's problem behaviors within the classroom rather than by removal from the classroom. This has important implications as a child's ability to maintain their behavior in the classroom is a good indicator of their ability to transition to a less restrictive setting.

As mentioned earlier, another area of concern was our shrinking census related to often conflictual relationships with special education directors. Special education directors were looking for programs that offered a variety of services with a flexible length of stay. The "old" program offered no such flexibility. As such, our second task over the past eighteen months has been to become more flexible.

We first met with a representative group of special education directors in order to hear their complaints and discuss their needs. This meeting was an important first step towards working collaboratively with special education directors. The directors expressed a need for more short-term diagnostic placements which would result in detailed recommendations for community schools to follow. They also requested lower cost alternatives to our intensive program as well as increased involvement by us in their community schools.

As special education departments then began to send us children specifically for short-term placements, we had the opportunity to show that we could accomplish this task. After a child had been admitted, we maintained frequent communication with the director during the child's 4 to 6 week diagnostic placement. Our staff focused on determining what the child would need in order to function in a community school. For example, did the child need a self-contained classroom? How did the child respond to the behavior management strategies used in the classroom? Was individual therapy likely to be helpful? Can the family access and use family therapy? At the end of the diagnostic placement, the treatment team met with the family and special education director in order to share results of these assessments and make recommendations. A transition plan was developed and a time line was set.

We also are in the process of starting "transition classrooms" for children who have been in the regular Bradley School but are not quite ready to return to community schools. The transition classrooms will be offered at a lower cost. The plan is to first transition the therapies from on site to off site. Children in the transition classrooms will receive their therapies elsewhere in the community. One of the focuses of the transition classrooms will be to gradually prepare the children for their eventual return to the community.

Over the past eighteen months, we have seen an improvement in our relationships with special education directors as well as an increase in our census. For example, the census in the "old"Bradley School hovered around 50 while our current census fluctuates between 55 and 60. Moreover, we typically get no referrals during the months of July and August when public school is not in session. However, this summer, we have had 4 referrals.

We plan to continue to expand our continuum of services as a way of staying flexible. Our intention is to provide high quality clinical care while remaining sensitive to the needs of special education directors and the community. This likely will mean that the census in our "regular" Bradley School will decrease slightly as the census in our less intensive programs increases.

Table 1: RESTRAINTS IN THE BRADLEY SCHOOL (1992)

Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
67	44	19	11

Table 2: CRISIS INCIDENTS IN THE BRADLEY SCHOOL (1992)

Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
224	162	73	66

NOTEInservicing was conducted during the Apr-Jun quarter.